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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/22/18-08/23/18.	{D 000}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the electronic medication record (eMAR) was accurate for 2 of 6 sampled residents (#4 and #6) related to continued documentation of administration for a discontinued anti-hypertension medication (#4) and a blood thinner documented as administered but was not	D 367		

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available (#6) related to Plavix 75 mg (used to prevent heart attack and stroke) initial as administer to the resident, but not on hand.

The findings are:

1. Review of Resident #4's current FL-2 dated 02/27/18 revealed:
-Diagnoses included hypertension with electrolyte imbalance.
-An order for Losartan 50 mg take one tablet daily (Losartan 50 mg is anti-hypertensive medication).

Review of Resident #4's physician orders dated 07/24/18 revealed an order to discontinue losartan 50 mg tablet daily and initiate losartan 50-12.5 mg daily (combo).

Review of Resident #4's July 2018 eMAR revealed:
-There was an entry for Losartan 50 mg take one tablet daily, scheduled for 8:00 am.
-There was documentation of administration from 07/01/18 to 07/31/18 at 8:00 am.

Review of Resident #4's monthly vital sign log revealed a blood pressure of 138/72 for July 2018.

Review of Resident #4's August 2018 eMAR revealed:
-There was an entry for Losartan 50 mg take one tablet daily, scheduled for 8:00 am.
-There was documentation of administration from 08/01/18 to 08/22/18.
-There was no documentation indicating the medication was discontinued.

Review of the facility vital sign list for August 2018 revealed Resident #4's blood pressure was

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D 367	Continued From page 2 120/60. Observation of the medications on hand for Resident #4 with the Resident Care Coordinator (RCC) on 08/22/18 at 5:00 pm revealed: -A blister package of Losartan 50 mg tablets was available for administration. -There were 24 of 30 tablets in the package. -The RCC removed the blister package of Losartan 50 mg from the medication cart. Interview with Resident #4 on 08/23/18 at 12:56 pm revealed: -She did not recall what medications she received at the 8:00 am medication pass. -She had not run out of any prescribed medications. -She did not have any episodes of dizziness or recent falls. -No one told her there was a problem with her blood pressure readings. Interview with a representative from the pharmacy on 08/23/18 at 11:15 am revealed: -Losartan 50 mg was dispensed on 07/10/18 for Resident #4 and it was a thirty day supply. -There was a discontinued order for Losartan 50 mg written and received on 07/24/18. -The discontinued order for Losartan 50 mg was placed into the main computer system, but the discontinue order did not translate to the eMAR system causing the order to still appear on Resident #4's eMAR. -This type of error had occurred before and was usually discovered by facilities. -When facilities discovered entries on the eMAR that were discontinued, they contacted them and the entry had to be manually removed. -Resident #4's Losartan 50 mg order was manually removed from the eMAR once the	D 367		

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facility staff notified the pharmacy on 08/22/18 in the afternoon.
-There was no explanation for why this type of error occurred.
-There were no plans to resolve the issue within the computer system.
-There was no guarantee that the same error would not happen again.

Interview with a first shift medication aide (MA) on 08/23/18 at 11:56 am revealed:
-There were three dates on the August 2018 eMAR where her initials appeared, 08/10/18, 08/18/18, and 08/19/18.
-She did not recall administering Losartan 50 mg because Resident #4 received many tablets at 8:00 am.
-When she noted an error on the eMAR, she reported it to the RCC.
-She did not note the two entries for Losartan on the eMAR and did not report it to the RCC.

Attempted telephone interview with another first shift MA on 08/23/18 at 3:11 pm was unsuccessful.

Telephone interview with a third first shift MA on 08/23/18 at 3:29 pm revealed:
-She verified her initials appeared on the eMAR and that she worked on 07/26/18, 07/31/18, 08/04/18, and 08/05/18.
-She did not recall seeing two orders for Losartan.
-She did not recall administering two medications with Losartan to Resident #4.
-When she noted an error on the eMAR, she reported it to the RCC, but she did not report any issues with Resident #4's medication.

Interview with another third shift MA on 08/23/18

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at 3:40 pm revealed:
-She was working overtime to assist the facility.
-There was one date on the August 2018 eMAR where her initials were documented on 08/11/18.
-She may have documented the administration because she was not relieved by a first shift MA.
-She did not recall administering the discontinued Losartan to Resident #4.
-She told the RCC when an error was noted on the eMAR.
-She did not recall seeing two entries for Losartan on Resident #4's eMAR because she usually worked third shift and did not administer medications on first shift often.

Telephone interview with a second and third shift MA on 08/23/18 at 4:47 pm revealed:
-She verified her initials appeared on the eMAR and that she could not recall working on 07/29/18.
-She did not recall working on first shift to administer medications.
-She did not recall medications for Resident #4 and thought her initials appearing on 07/29/18 was an error.

Interview with Resident #4's Physician Assistant's (PA) medical assistant on 08/23/18 at 10:50 am revealed:
-Resident #4 was prescribed Losartan/Hydrochlorothiazide 50-12.5 mg (combination tablet) one tablet daily on 07/24/18.
-An order to discontinue Losartan 50 mg was written on 07/24/18 for Resident #4.
-The facility staff notified the PA on 08/22/18 concerning Resident #4 possibly receiving both the Losartan 50 mg and Losartan/Hydrochlorothiazide 50mg/12.5 mg.
-The Losartan 50 mg and Losartan/Hydrochlorothiazide 50-12.5 mg were prescribed to treat Resident #4's hypertension.

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-The possible effect of receiving both medications was low blood pressure.
-Resident #4's blood pressures were measured as follows: on 08/21/18 the blood pressure was 110/74, on 07/24/18 the blood pressure was 112/70, and June 2018 the blood pressure was 116/70.

Interview with the contract pharmacist on 08/23/18 at 2:41 pm revealed:
-She completed the last pharmacy medication review for Resident #4 on 07/14/18.
-She did not know that Resident #4 had a discontinued order for Losartan 50 mg written on 07/24/18 until 08/23/18 and she was able to see the order in the computer system.
-She was able to view the new combination medication order for Resident #4, Losartan/Hydrochlorothiazide 50 mg/12.5 mg written and dispensed on 07/24/18.
-She did not know that Resident #4's July 2018 and August 2018 eMARs continued to show the discontinued Losartan 50 mg.
-She did not know of any other occurrences of this type of error during her three years with the contract pharmacy.
-Resident #4 was using Losartan to treat hypertension.
-If Resident #4 was administered both medications it may lower her blood pressure, however Losartan 100 mg was not an overdose of the medication.

Interview with the RCC on 08/23/18 at 4:55 pm revealed:
-Physician orders for discontinued medications were sent to the pharmacy via fax.
-The pharmacy would discontinue medications on the eMAR system.
-The MA would remove the medication from the

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medication cart and place in the bin to return any remaining medication to pharmacy.
-Resident #4's order to discontinue the Losartan 50 mg was sent to the contract pharmacy on 07/24/18.
-The pharmacy reported that it was received, but an error occurred.
-The discontinue order for Losartan 50 mg was placed into the contract pharmacy's main computer system but it did not translate over to Resident #4's eMARs.
-She completed daily and weekly eMAR audits but she did not catch the error on Resident #4's eMAR.
-She was responsible for reviewing the eMARs and sending physician orders to the pharmacy.
-She had spoken with another MA to come up with a plan to prevent any other errors such as this one and she would assist with auditing the eMARs against daily physician orders.

Refer to interview with the RCC on 08/23/18 at 11:40am.

2. Review of Resident #6's current FL-2 dated 03/27/18 revealed:
-Diagnoses included vascular dementia without behaviors, anxiety disorder, hypertension, hyperthyroidism and chronic renal disease (CRD).
-There was a medication order for Plavix 75 mg daily (Plavix is blood thinner).

Observation of the medication pass on 08/23/18 at 9:00am revealed Plavix was not administered to Resident #6 by the medication aide (MA).

Review of Resident #6's Electronic Medication Records (e-MAR) for June 2018 revealed:

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-An entry for Plavix 75 mg daily scheduled for administration at 8:00am.
-There was documentation of administration of Plavix 75mg at 8:00am.from 06/01/18-06/30/18.

Review of Resident #6's e-MAR for July 2018 revealed:
-An entry for Plavix 75 mg daily scheduled for administration at 8:00am.
-There was documentation of administration of Plavix 75mg at 8:00am from 07/01/18-07/31/18.

Review of Resident #6's e-MARs for August 2018 revealed:
-An entry for Plavix 75 mg daily scheduled for administration at 8:00am.
-There was documentation of administration of Plavix 75mg at 8:00am from 08/01/18-08-08/23/18.

Review of Resident #6's 08/2018 e-MARs on 08/23/18 revealed there was an initial documenting Resident #6's Plavix had been administered at 9:00am.

Interview with the medication aide (MA) on 08/23/18 at 10:26am revealed:
-She was aware Resident #6 did not have Plavix on hand during the medication pass on 08/23/18.
-Resident #6 ran out of Plavix 75 mg yesterday.
-She did not know why the MA had not reordered Plavix.
-She could not say why she initialed the e-MAR as though she had administered Plavix to Resident #6 on 08/23/18 at 9:00 am.
-She should have circled her initial and wrote a note.
-She would notify the Resident Care Coordinator (RCC) that Resident #6 had run out of Plavix.

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Telephone interview with Resident #6's primary care provider's (PCP) nurse on 08/23/18 at 11:05am revealed:
-The PCP had been notified on 08/23/18 at 8:00am that Resident #6 did not get her Plavix.
-This was the only time the PCP had been notified Resident #6 had run out of Plavix.
-The medication had been prescribed for congestive heart failure, to prevent fluid buildup in heart and legs, to help prevent stroke, heart attack and other types of heart problems.

Telephone interview with the pharmacist on 08/23/18 at 2:30pm revealed:
-A 30 day supply of Plavix had been dispensed on 08/08/18.
-Plavix 75 mg was dispensed on 08/23/18.

Interview with the RCC on 08/23/18 at 11:35am revealed:
-She had been notified on 08/23/18 (no time) that Resident #6 ran out of Plavix.
-She did not know why the MA had initialed the e-MAR as though she had administered Plavix to Resident #6 on 08/23/18 at 9:00 am.
-The MA should have circled her initials and wrote a note.

Attempted telephone interview with a MA on 08/23/18 at 11:41am who gave medications on 08/22/18 first shift was unsuccessful.

Refer to interview with the RCC on 08/23/18 at 11:40am.

Interview with the RCC on 08/23/18 at 11:40am revealed:
-The Administrator was not available for interview on 08/23/18.
-The Administrator had referred all survey

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